

Results. In 2013, >1 antibiotic dose/day was prescribed to 16.2% of VA dental patients (total = 476,451 patients). By class, aminopenicillins were most frequently prescribed (69.4%), followed by lincosamides (21.9%). The overall mean AD was 11.4 (range = 1–309) days and DOT was 11.5 (1–309). Of the Veterans who received an antibiotic from a dentist, only 2.3% received a broad-spectrum agent. However, broad-spectrum AD (15.0) was significantly longer than narrow spectrum AD (11.2; $P < 0.0001$).

Conclusion. While the prevalence of broad-spectrum prescribing was low, the patient-level duration of antibiotics prescribed by VA dentists is surprising. Thus, there may be an opportunity to expand antimicrobial stewardship efforts to dental providers.

Disclosures. J. C. McGregor, Merck & Co.: Grant Investigator, Research grant

692. Use of Antibiotic Prophylaxis for Tooth Extractions, Dental Implants and Periodontal Surgical Procedures

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Background. Guidelines for dental procedure antibiotic prophylaxis have changed significantly, reducing the number of patients indicated to receive antibiotics. The primary objective was to determine the frequency and appropriateness of dental antibiotic prophylaxis at a VA dental clinic.

Methods. This was a cross-sectional study of patients undergoing tooth extractions, dental implants and periodontal procedures in 2015. These procedures are among the most common procedures with the potential for bacteremia post-dental procedure. Patients receiving antibiotics for a separate oral or non-oral infection on the date of the dental procedure were excluded.

Results. Of 183 Veterans undergoing the included dental procedures, 82.5% received antibiotic prophylaxis. Amoxicillin (71.3% of antibiotics) and clindamycin (23.8%) were prescribed most frequently; 44.7% of clindamycin was prescribed to patients not labeled as penicillin allergic. The mean duration of antibiotics was 7.1 +/- 1.6 (1–14) days; 82.5% receiving seven days supply. Of those that received antibiotic prophylaxis, 92.1% received post-procedure antibiotics only, 2.6% pre-procedural antibiotics only and 5.3% received pre- and post-procedure antibiotics. When prophylaxis was indicated (procedure and/or cardiac condition), 85.3% received an antibiotic. However, 72.7% received post-procedure antibiotics when only pre-procedure administration was indicated. When pre-procedure antibiotics were indicated, 11.5% did not receive any antibiotics (pre- or post-procedure). Only 8.2% received antibiotics appropriately based on administration time, procedure and co-morbidities. Three months post-procedure, there were no occurrences of *Clostridium difficile*, infective endocarditis, prosthetic joint infections or oral infections.

Conclusion. The majority of patients undergoing a dental procedure received antibiotic prophylaxis. While the majority of these antibiotics were indicated pre-procedure, prescribing of post-procedure antibiotic for excessive durations was frequent. Dental stewardship efforts should ensure appropriate timing, indications, and duration of antibiotic prophylaxis.

Disclosures. All authors: No reported disclosures.

693. Preparing for The Joint Commission Standard on Antimicrobial Stewardship: Practical Tips for Survey Success

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Background. Effective January 1, 2017, Standard MM.09.01.01 addressing antimicrobial stewardship is enforceable by The Joint Commission (TJC). In order to ensure TJC survey success, we implemented a systematic approach to address each associated Element of Performance.

Methods. Upon notification of TJC Pre-Publication Standard MM.09.01.01 in 2016, we held an Antimicrobial Stewardship Program (ASP) team Transformational Summit, at which time we developed a strategic plan including goals and programs aimed at optimizing our existing program and satisfying TJC ASP Standard. Members of our ASP include Infectious Diseases pharmacists and physicians, pharmacy administration, the microbiology laboratory directors, infection preventionists, and a data manager.

Results. Specific programs developed to meet each Element of Performance included: (EP1) composing a strategic plan based on TJC ASP standard and an ASP letter of support for senior leadership to endorse; (EP2) developing an educational program for providers including a required eLearning module and work station screensavers regarding antimicrobial resistance and stewardship principles; (EP3) creating educational materials for patients to view during their inpatient stay via our online portal and creating patient-directed screensavers for the in- and outpatient settings; (EP4) expanding our ASP team to include additional members; (EP5) implementing a hospital-wide antibiotic time-out program and a plan for providing drug use feedback to front-line providers; (EP6) updating guidelines for the management of pneumonia and MRSA bacteremia and developing a systematic approach for prospective audit and feedback of restricted

antimicrobials; (EP7) constructing a dashboard for tracking antimicrobial use and cost trends; (EP8) creating an ASP intervention worklist in our electronic health record identifying patients with positive blood cultures and those on high-risk antimicrobials.

Conclusion. As a result of TJC Standard MM.09.01.01 regarding antimicrobial stewardship, a systematic approach to addressing each Element of Performance was developed. Sharing the details of our approach may benefit other institutions as they prepare the TJC survey.

Disclosures. All authors: No reported disclosures.

694. What Do They Want? A Survey of Residents' Attitudes of Procalcitonin Use and Appropriate Utilization

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Background. Procalcitonin (PCT) is a proven tool to guide optimal antibiotic utilization. Physician attitudes towards PCT play a critical role in optimal PCT use. This study was an initial step in developing an antibiotic stewardship intervention for antibiotic de-escalation targeting physician trainees.

Methods. We used an electronic mailing list to distribute an anonymous survey to all internal medicine residents. The survey included 13 multiple-choice questions to assess attitudes and self-reported use of PCT and 3 case-based questions to gauge application of PCT in clinical practice. Residents provided gift cards as an incentive for completion.

Results. A total of 94% (113/120) of residents responded to the survey. Only 22% reported using PCT prior to residency. One-third of residents order PCT at admission and 48 hours later for patients with suspected infections, while another third order PCT on admission only.

Most found an elevated PCT useful (> or = 3 on a scale from 1–5, 5 most useful), with 84% stating PCT helps in discontinuing antibiotics. When asked why PCT was unhelpful, 71% of residents found it difficult to interpret and 48% reported PCT does not change management. Almost all residents desired additional PCT education. Half of residents thought point of care PCT interpretation in the electronic medical record (EMR) would be valuable.

In the case-based questions, 77% did not start antibiotics for a patient with an elevated PCT and no infectious symptoms. In another case, 81% chose to stop empiric antibiotics on day 7 for a patient with unspecified sepsis with clinical improvement, negative infectious workup and PCT of 0.2 ng/dL (Figure 1).

Conclusion. Despite over two-thirds of residents reporting uncertainty with PCT, the majority of residents interpreted PCT correctly within the case-based questions to de-escalate antibiotics. Based upon these results, we will implement point of care PCT guidelines in the EMR as part of the antibiotic timeout. We will further validate reported PCT use by analysis of EMR data on PCT ordering rates among residents.

Figure 1: Responses for case-based question for clinical management of undifferentiated sepsis started on empiric antibiotics with procalcitonin of 0.2 ng/dL on day 7 and negative blood, urine and sputum cultures.

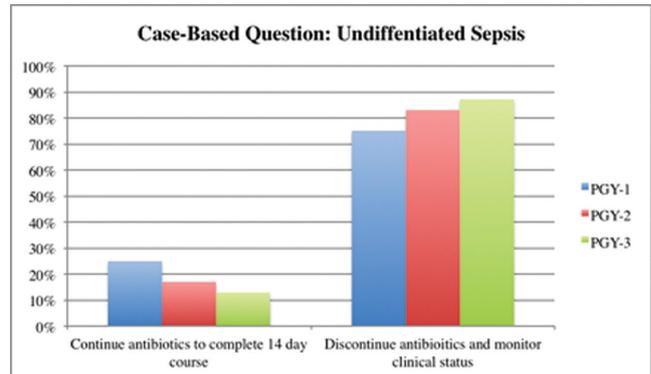
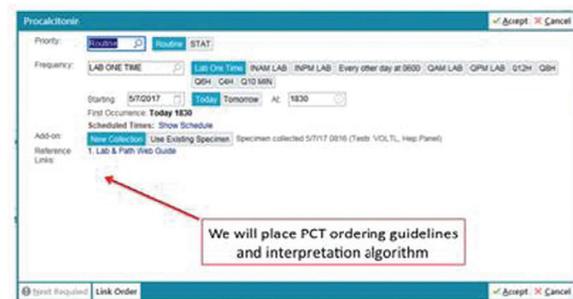


Figure 2: Current procalcitonin order.



Disclosures. All authors: No reported disclosures.